WORLD RELIEF

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Vurhonga II CSXV Child Survival Project
THIRD ANNUAL REPORT

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ACRONYMS

CBHIS	**Community Based Health Information System**
CSP	**Child Survival Project**
DIP	**Detailed Implementation Plan**
HQ	**Headquarters**
IMCI	**Integrated Management of Childhood Illness**
ITN	**Insecticide Treated Net**
KPC	**Knowledge, Practice and Coverage**
MOH	**Ministry of Health**
STI	**Sexually Transmitted Infection**
VHC	**Village Health Committee**
WR	**World Relief**

A. Progress towards objectives

In its third year, Vurhonga II succeeded in reaching most end of project objectives. Only two of 24 objectives remain to be met, one of which fell short by just 1%. Of fourteen measurable objectives with final targets under 80%, Vurhonga II exceeded the final goal on seven of them by over 20%.

The Table below summarizes progress towards project objectives using results from the July 2002 survey, unless otherwise noted. Data from the entire series of surveys can be viewed in Appendix A to provide a picture of progress over time.

Progress Towards Final Objectives: End of Year Three		
Objectives		**Progress**
Nutrition		
1a.	Increase from **75%** to **85%** the number of children 0-35 months weighed at least once during last 3 months	Yes: 90%
1b.	Increase from **22%** to **80%** the number of malnourished children's mothers who received nutrition counseling.	Yes: 84%
	Comment: Nutrition counseling peaked at 96% in April 2002.	
1c.	Increase from **50%** to **70%** the number of malnourished children who received nutritious foods/enriched porridge	Yes: 98%
2.	At least **70%** of children who completed the HEARTH program achieve and sustain adequate or catch-up growth per month during at least 2 months after HEARTH.	Yes: 73% (Nov 2001)
Maternal Care		
3.	Increase from **45%** to **70%** the number of mothers who eat the same amount or more food during pregnancy.	Yes: 84%
Malaria		
4a.	Increase from **28%** to **75%** the number of children treated within 24h for fever (suspected malaria) at any health facility.	Yes: 92%
4b.	Compliance with Chloroquin treatment for Malaria should at least be **75%** for patients treated at a health facility during the last 2 weeks.	Yes: 95%
	Comment: This objective for treatment compliance was added at mid-term and is verified by asking to see the pill packaging to confirm that no doses are left.	
5.	Increase from **0.3%** tot **70%** the proportion of children under 5 who use insecticide treated nets year round.	Yes: 81%
	Comment: ITN use has seasonal peaks between 90-95% during months when mosquitoes are perceived to be more bothersome. When usage decreased to 57% in August 2001, BCC messages were revised to reinforce the importance of year-round use and coverage improved to above target levels—though usage is still highest during "mosquito season."	
Pneumonia		
6.	Increase from **2%** to **50%** the number of children treated within 24h for rapid, difficult breathing at appropriate health facility	Yes: 85%
Diarrhea		
7.	Increase from **53%** to **75%** the proportion of children with diarrhea treated with ORT by mothers/volunteers.	Yes: 98%
8.	Increase from **19%** to **65%** the proportion of mothers who give extra food to children for 2 weeks following diarrhea.	Yes: 87%
Reproductive health		

9.	Increase from **0.3%** to **40%** the number of mothers who know 3 ways to prevent transmission of STI's including HIV/AIDS.	Yes: 40%
10.	Increase from **1.6%** to **40%** the number of women and partners who recognize at least 3 common symptoms of STI's.	Yes: 41%
11.	Increase from **0.3%** to **40%** the number of women and partners who recognize that STI's increase risk of HIV/infertility.	Yes: 28%
	Comment: In response to the slower progress in meeting this objective (relative to others), the staff created in October 2002 a new pictorial teaching aid to assist in communicating about STIs.	
12.	Increase from **65%** to **85%** the number of mothers who deliver child by trained provider.	Yes: 88%
13.	Increase from **3%** to **20%** the number of women who are using a modern method of birth spacing.	Yes: 23%
Immunization		
14.	Increase from **74%** to **90%** the number of children 1-2 years old that are fully vaccinated.	Yes: 89%
	Comment: Immunization is not an official intervention or objective of Vurhonga 2 but project animators do actively mobilize the communities to participate in MOH immunization outreach, with measurable impact. The CSP was encouraged to track immunization coverage at its DIP review.	
Capacity Building and Sustainability		
15.	Increase to **100%** the Health facility based providers who have received continuing education in Malaria and Pneumonia protocols.	Yes: 100%
16.	**50%** of beneficiaries will report that they are satisfied with their last visit to an MOH facility.	Yes: 100%
17.	At least **50%** of mothers that attended church last month will report that they heard a health message.	Yes: 71%
18.	At least **70%** of the 48 Village Health Committees will have met once in the last 2 months.	Yes: 89%
19.	Chloroquin will not be out of stock for more than 3 days per month in at least **90%** of health posts.	Yes: 94%
20.	**75%** of Socorristas will have received a supervisory visit from Chokwe district staff or Vurhonga project director within the previous quarter.	Yes: 100%
21.	Increase access to a health post within 5 km radius, staffed with trained personnel and equipped with essential supplies from 65% to **90%** in the project area.	Yes: 99%
22.	At least **80%** of families have been visited by their volunteer during the past 2 weeks.	Yes: 88%
23.	The monthly attendance rate for church leaders at the health meetings will be at least **60%.**	Yes: 63%
24.	Joint meetings between project and DHMT at least once a quarter to review the Vurhonga II project HIS and plans for upcoming quarter.	Yes: 100%
25.	Preparation of monthly consolidated reports from all health posts by district statistician.	Yes: 100%

B. Challenges to Achievement of Objectives

The only objective that has not yet been met regards knowledge of sexually transmitted infections (STIs)—specifically that STIs increase risk of HIV transmission and infertility. Vurhonga staff felt challenged to create pictures for teaching on STIs that would be sufficiently explicit to communicate the content without being so distasteful as to alienate pastors and mother volunteers from using them. As a result, the staff initially tried relying exclusively on verbal communication regarding STIs. However, when knowledge on STIs was shown to be lacking in comparison to other, more visually represented information, the staff overcame their hesitancy and developed visual aids on the topic with pastors' input to ensure acceptability for use in churches. These pictures, already produced, will be used during the final year of the project for training volunteers, mothers, pastors and their congregations.

C. Technical Assistance

Vurhonga II is performing well in all areas. Thus, technical assistance of interest to the project pertains to research rather than program functioning. The project has amassed a wealth of hand-tabulated data pertaining to Hearth outcomes and would appreciate assistance with this data analysis.

D. Changes to DIP and Program Monitoring

There have been no significant changes to the Detailed Implementation Plan (DIP) requiring modification of the Cooperative Agreement.

Program Monitoring

Successful community-based programs blend reliable and timely quantitative data with structured systems of personalized feedback to craft strategy and evaluate progress. The Vurhonga project provides both. In addition to baseline and final 30 cluster Knowledge, Practices and Coverage (KPC) survey, quarterly surveys and a community-based health information system (CBHIS) provide reliable quantitative indictors of progress toward project goals. Additionally, the systematic observations by supervisors and the weekly and monthly reports by animators provide personalized feedback loops. Project staff use the data from the monitoring system in guiding the project. As important to the sustainability strategy, the MOH and community partners also use key data to chart their progress and craft their strategies.

1. Personalized feedback loops for program management

Supervision

Each supervisor monitors the activities of five or six animators. On Monday to Thursday, the supervisors live in the field with their animators, normally visiting two or three in each week but altering their schedule to address special needs. They participate in care

group training sessions to observe the animators training the volunteers and provide supportive feedback to improve or to praise the content and methods of training. They also do random household visits to evaluate the knowledge, practice and attitudes of the women and to reinforce the work of the animators and volunteers. The animators report any important activities to their supervisors on a weekly basis. Regular feedback and reporting of potential problems allows for timely resolution at the field level or through wider discussion on Fridays.

Weekly and monthly reports by the Animators

The animators report weekly to their supervisors concerning important activities or problems that they encountered during the week. When they all come back from the field on Fridays, the entire project staff meet together to celebrate accomplishments, address emerging problems and craft solutions. The supervisors also meet with the project director to discuss issues or problems that are more appropriately addressed in a smaller group.

2. Quantitative monitoring

Quarterly surveys

Since September 2000, the Vurhonga II project has conducted a series of quarterly surveys to measure progress on key indicators using a subset of questions from the KPC. Each quarterly survey encompasses about one-eighth of the project households chosen randomly in clusters by care group. Each animator surveys all the households of one care group chosen at random in another animator's area resulting in a sample size of 100 and 150 women of reproductive age per animator. The quarterly survey data are tabulated manually by each animator and then compiled and discussed during their weekly meetings with the project director and the supervisors. Since each animator's area is relatively homogeneous, the successive quarterly surveys allow for monitoring their performance and for cross-comparison among them. If the progress of one animator lags significantly behind that of others, the supervisor and project director ascertain the reasons and either address the problem in the community or improve the performance of the animator. The aggregated data correspond well to the data collected in full-scale KPCs and enable the project staff to monitor overall progress. The confidence intervals of the estimates are not routinely calculated but most likely would be smaller than those obtained with the KPC survey since the sample size is much larger.

Project staff share the findings of the quarterly surveys with the MOH and with the Village Health Committees (VHCs) and care groups whose areas were surveyed. The discussion of the results at this level catalyze interaction concerning individual households and the identification of those that may be at risk. For example, if a child is underweight and did not get enriched porridge the animator and volunteer try to understand why the mother why did not prepare any enriched porridge and how this may be addressed.

The community-based health information system (CBHIS).

The monthly care group meeting is the basic unit for the collection of data on deaths of children under five, pregnancies and birth outcomes. Each volunteer reports orally on any of these events in her households and her report is transcribed and aggregated with those of the other volunteers by the care group leader. For each death of a child under five, the age group (< 1, and 1-4) and the cause is also recorded. The care group leader or another volunteer visit any volunteers who are absent from meetings to collect the data and also to understand why she may have missed the meeting.

At the level of the care group, the information system catalyzes discussions concerning deaths, the needs of individual families and absent volunteers, and enables double-checking of the data at the most basic level. The care group discusses the implications of the findings and actions for the community and the volunteers. The CG leaders also report all the information that pertains to the families of her Care group to the VHC. The *Socorrista* or *Chefe de Saude* may then lead any discussions or ask any questions related to the reports. As one village leader mentioned: "The *Socorrista* or the *Chefe de Saude* gives a written report of what's been done in the community. It is helpful to know better what is going on in the community. The information includes deaths, diseases, deliveries at home or at the hospital, etc."

The health information system is thoroughly integrated with that of the MOH. The *Chefe de Saude* (leader of the village health committee) collects the information from the CG leaders in the village and compiles it in one report before handing it over to the village *Socorrista* (MOH-trained provider of first aid) or nurse. The *Socorrista* then reviews it and adds his or her statistics and comments on the same form. Each *Socorrista* reports the data to the district MOH officer at the end of the month to be entered on computer. The summary reports by the nurse or *Socorrista* also help the MOH District officer to detect and address discrepancies among the various health posts. The MOH District officer commented that the information from the Vurhonga community-based HIS is very useful and that they want to keep collecting information on morbidity and mortality in the community, not just in the hospital and health centers

World Relief shared its experiences with using project data for decision making by project staff, local communities and district MOH partners at the September 2002 Data for Action Workshop held in Silver Spring, MD.

E. Discussion of MTE Recommendations

Vurhonga staff consistently incorporated recommendations from the mid-term evaluation into the ongoing project. The action plan created at the time of the evaluation is presented below, along with the project's response to each recommendation.

MTE RECOMMENDATIONS ACTION PLAN – September'01			
	Recommendations	**Responsibility**	**Target Date**
A	**Malaria**		
	1. The Vurhonga project should regularly review the MOH statistics tracking the availability of chloroquin at health posts.	Project Director	Quarterly

Response: The tracking of chloroquin availability at health posts was added to the monthly reports made by *Socorristas* in February 2002. Initially the drug supply was negatively affected due to delays in delivery of "Kit C" drugs. (Kit C includes Chloroquin and is what the MOH provides to *Socorristas* for their work at health posts.) To compensate for this, *Socorristas* had to replenish their stocks using the hospital's supply. This helped though quantities were often carefully rationed. The problem was resolved in April 2002 when the MOH received its delayed order of Kit C from WHO. Once the MOH's supply of Kit C had been replenished, running out of stock at the health posts could be attributed directly to the *Socorristas.* Since April, over 90% of *Socorristas* have succeeded in maintaining a constant supply of chloroquin. In follow-up with those who did run out for three days or more, it was found that stock-outs tended to occur on weekends when the office for requesting supply was closed.

	2. The Vurhonga animators and volunteers should reinforce messages related to year-round use of ITNs, and in particular for children under five.	Animators and volunteers	Jan '02

Response: Messages related to year-round use of ITNs were reinforced shortly after the MTE as well as during the ITN re-treatment sessions that took place the first 2 weeks of May 2002. There was a marked improvement of ITN use during winter (81%) compared to the previous year (68%).

	3. The Vurhonga project should follow up with the MOH, UNICEF, and PSI to encourage them to soon make ITNs and re-treatment available at low cost in the villages.	Project Director	27/9/01

Response: The project has been in regular contact with UNICEF/Roll Back Malaria so as to facilitate ITN sales and re-treatment in Chokwe as soon as possible. Meredith Gaffney, the UNICEF representative for Gaza Province communicated September 27, 2002 that they were just then in the final stages of making ITNs and insecticide available at health centers and health posts in Gaza. The remaining step before implementation regards determination of subsidized pricing by UNICEF. Factors for consideration include affordability as well as private sector sales.

	4. The Vurhonga project should encourage the Village Health Committees to address and develop solutions to the issue of referral in their community.	Animators	Dec. '01

Response: All 48 Village Health Committees have discussed at length the issue of emergency transport for referral to the health center or hospital. Forty-five of the villages created written plans for emergency transport. Solutions proposed vary widely, depending on the resources of the village and its residents. Modes of transport included ox-carts, bicycles, and private motor vehicle with fuel paid for by the patient.

	5. The Vurhonga project should consider assessing compliance with malaria treatment received in health posts in one of the HIS quarterly surveys.	Animators	Dec.'01

Response: Vurhonga set a target of 70% for treatment compliance with chloroquin and added a corresponding indicator to those tracked by the quarterly surveys. On the survey, mothers of children who had been treated for malaria in the prior two weeks were asked to produce the packet in which the medicine had been dispensed. They were then asked how and for how many days the chloroquin had been used. If any chloroquin tablets were left in the packet, failure to comply with the correct dose and timing was assumed. In quarterly surveys from March and July 2002, compliance was found to be 90% and 95% respectively.

B	**Diarrhea**		
	1. The Vurhonga project should continue monitoring latrine coverage and use in the community; volunteers (and village leaders, as necessary) should follow up with families who do not yet have latrines.	Animators and VHC's	Monthly

Response: The community HIS records the number of families without latrines as reported by Care Group volunteers and compiled by Care Group leaders. At the start of the project in October 1999, only 7,399 families (17%) had latrines in Chokwe district. In October'02 a latrine census was done and a total of 19,465 families (66%) then had latrines. The numbers are still increasing monthly. The rate of increase depends both on the strength of the leadership of the village and also on the type of soil in the area. In some villages, local leadership has mandated latrine construction for all residents, even going so far as to build latrines for those families that don't and then obliging them to pay for the labor. Sandy soil slows down rate of latrine construction as materials like wood or brick are required to reinforce the walls of the pit to prevent collapse.

	2. The Vurhonga project should continue monitoring the weaning of babies with diarrhea to ensure that this harmful practice decreases.	Animators VHCs Volunteers	Ongoing

Response: The importance of breastfeeding babies with diarrhea has been re-emphasized in Care Group training sessions and volunteers report that the practice has become very rare. No known incident of this practice has occurred during the last 6 months of year three.

C	**Nutrition**		
	1. The Vurhonga project should consider encouraging mothers to make dried greens during the rainy season when they are plentiful—a traditional practice that was discontinued years ago, and promoting marula nut trees in Chokwe district for long-term nutritional benefit.	Supervisors Animators Volunteers	Jan.'02

Response: Approximately 60% of all volunteers made dried greens during the last rainy season but not in sufficient quantity to last for the year. Only 3 volunteers still had more than a 50kg bag full of dried greens in June'02. They were praised and were given seeds as incentives for each full bag. The main leaves used were cassava and pumpkin leaves. Many volunteers had thought that they would dry leaves later during the rainy season but an early drought thwarted their plans. A lesson was learned not to delay preparing greens until late in the season. People liked the greens and will start earlier in the season next year.

D	**MOH Strengthening**		
	1. a)The MOH District should make a supervisory visit to each village at least once a quarter to supervise the *socorristas* and *chefes de saude* and deal with any issues from the VHC or the volunteers. The MOH and the Vurhonga project should define the scope, the tools, and the resources needed for this important task. The MOH should share their monthly report on supervision of *socorristas* with the Vurhonga project. b) Vurhonga should assist the MOH with maintenance of the motorbike, office supply, and c) the management and analysis of the supervision data.	a)MOH H/P supervisor b)W/R mechanic c)Proj. director	a)Quarterly b)As needed c)Nov.'01

Response:

a) The MOH person responsible for supervision of *Socorristas* (Inacio Xitlhangu) received a 50CC motorbike from Med Air and is using it to supervise nearby villages. Vurhonga provides assistance with transport to more distant destinations, so long as the supervision plan is submitted one week in advance. Together with the Socorrista Supervisor, an instrument was developed to rate *Socorristas* according to performance, knowledge and attitude. The *Socorrista* Supervisor uses this tool to aid in supervision. All the *Socorristas* were visited at least once during the last quarter.

b) Motorbike maintenance is being done at the WR office on an as needed basis.

c) The project director has assisted with data management and analysis at the MOH by helping to program formulae into the spreadsheet to automate calculation of indicators.

	2. a)The Vurhonga project should continue monitoring the quality of care in the health centers and the health posts, including the availability of drugs, welcome, waiting time and b)other criteria as identified by the community.	a)MOH H/P Supervisor b)Animators	a)Quarterly b)Quarterly with HIS

Response:

a) Quality of care and availability of drugs are being monitored during supervision visits and Chloroquin stock is also monitored during the monthly reports that are read at the VHC meetings and sent to the hospital for tabulation.

b) During the quarterly surveys as part of the HIS, all mothers who took their children for treatment are asked whether they were satisfied with the care they received at the health post. More than 95% reported satisfaction.

E	**Church Strengthening**		
	1. The VHCs should communicate to church leaders the importance of letting the pastors trained in health education share the messages with their congregation.	Supervisors and Animators	Oct.'01

Response: Each VHC is attended by a church leader representative who communicates all information related to church matters to the rest of the pastors in their pastoral Care Goup. Extra attention has been given to those villages and denominations that have been less cooperative.

	2. The village leaders should follow up with churches that don't come to teachings or participate in council of churches to collaborate with the Vurhonga project on improving the community's health.	Village leaders	Ongoing

Response: This is also ongoing. As an example, in Zuza village one of the Zion church leaders did not want to participate in health activities. The village leader responded by saying that failure to participate would be interpreted to mean that the church was against improving health in the village and would result in closing down the church. They church decided to cooperate.

F	**VHC Strengthening**		
	1. The Vurhonga project and the MOH should prepare a written guideline on the creation and the operations of the VHCs that defines the role of the individual members. This guideline will be useful for the VHC members, the MOH *Socorristas* supervisor, and other agencies interested in developing VHCs outside of Chokwe.	Project Director	Dec.'01

Response: Guidelines for VHCs have been created as outlined in the recommendation. Said guidelines have already been used by Save the Children and the district MOH to start a VHC in Hokwe, the only village excluded from Vurhonga II's project area.

	2. The Vurhonga project should consider providing more training to village leaders and to the *chefes de saude* so they could be more involved and better serve the VHCs.	Project Director, Supervisors, Animators	April'02

Response: A training camp was held for the Animators during the 2nd week of July'02 to capacitate them to train *Chefes de Saude* and Village leaders. Topics covered included review of the Vurhonga curriculum, leadership skills and vision. The Animators were then paired in order to assist each other in training the *Chefes de Saude* and leaders in each of their villages. One week was used to train the village of one Animator while the other Animator's village got the training the following week.

	3. The animators should first give health lessons to VHCs so they are informed in advance of what is being taught in the community. The *chefes de saude* could use training on the content of the health topics themselves as well as on leadership skills relevant to running the VHC meetings and managing the volunteers, on the role of *socorristas.*	Animators	Monthly

Response: This has been done during VHC meetings and is ongoing.

G	MOH Service Statistics (Under HIS)		
	1. The Vurhonga project should work with the MOH District on managing and analyzing health services statistics. As these and the Vurhonga project data accumulate, it becomes necessary to develop a structured database that allows access to data a few years backward and to link data from different sources. This will support the management of the project and health services in the District, and will allow for a complete documentation of the project by 2003.	Project Director	Dec.'01
	2. The Vurhonga project should monitor carefully the development of the promising community-based health information system to assess what can be sustained at the end of the project. The animators and the MOH staff should then train and supervise the *socorristas* and Care Group leaders with respect to recording and reporting the community HIS data.	Animators	Ongoing

Response:
1) A databank has been developed for easy tabulation of the monthly HIS statistics from all of the *socorristas.* Formulas has been programmed in the spreadsheet so that indicators could be followed on individual and village level.

2) The community HIS initially encountered problems related to low literacy. Illiterate volunteers had difficulty reading road to health cards to determine the age of the child and whether or not it had been weighed in the preceding three months. This problem was resolved by having the volunteers bring all road to health cards to their Care Group meeting so that literate volunteers could assist those who could not read. More capacity building is still needed and will continue to be given by the Animators, Supervisors and *Chefes de Saude*.

H	Sustainability		
	1. The Vurhonga project should prepare a detailed phase-out plan that includes:	Project Director	
	a. Activities with the MOH at the District level to develop:		
	• A policy for explicitly handing over responsibility for community health activities when health posts or district staff member are transferred	MOH District director	As needed
	• The leadership of the person in-charge of community health. That person should	MOH H/P supervisor	Dec.'02

	have all the information and skills needed, and be progressively given the authority and responsibility to apply them.		

Response: Policy for explicitly giving over responsibility for community health activities has been agreed upon verbally but not yet be documented on paper.

The supervisor for community health is gradually being given increased authority regarding volunteer activities. However, Socorrista activites remain the responsibility of the MOH health post supervisor.

	b. Activities to prepare for the future employment of the animators and supervisors	Administrator Supervisors	Dec.'02

Response: WR is applying for an Expanded Impact CS grant in Mozambique with a vision to scale up Vurhonga's Community IMCI interventions to 5 additional districts in Gaza Province. If the grant is awarded, all staff members will be encouraged to apply their eight years of experience with Vurhonga I and II to provide leadership in the 5 new districts.

	c. Activities at the Provincial and National level including advocacy and information dissemination (documentation; attendance to meetings; exchange visits with other community health and child survival projects)	Project Director Admin. assistant	Ongoing

Response: Vurhonga staff regularly participate in provincial level coordination meetings that take place every six months. They share feedback on the projects progress with Provincial MOH leadership and all other NGOs working in Gaza who attend said meetings. The Vurhonga staff are always open to hosting exchange visits with other WR CSPs and community health projects of other organizations. A visit from WR Rwanda's CSP is anticipated in the next quarter.

	d. Activities to empower the CG leaders and the *chefes de saude*. During the refresher training planned for the end of the project, for instance, only the CG leaders could be trained by the animators so that they can learn how to transfer their skills to the other volunteers.	Supervisors Animators	April '02 – July '03

Response: The same training that was given to the *Chefes de Saude* and village leaders was also given to all the Care group leaders and their deputy leaders during the last 2

weeks of July'02. It proved to be a good opportunity for the Animators to observe the skills of their Care Group leaders and to compare them with those of the neighboring Animators'. The health curriculum, training skills, leadership and vision were the main topics for training. The Care Group leaders formed their own group and will receive further refresher training from the Animator every 2nd week until the end of the project. Each volunteer Care Group leader replicated the training for their Care Group, with mentoring from their animator. A basic supervision guide has been made to assist the Animator supervising their training. The supervision checklist draws attention to whether or not volunteers sit in a circle so all are visible, the attendance register is used, the train promotes participation, training is well prepared, vital events reporting takes place, and planning takes place for the next meeting.

	e. Activities to prepare a complete documentation of the Vurhonga project by 2003,	Project Director	Ongoing

Response: To facilitate the complete documentation of the project at the end of FY 2003, all activities and important events pertaining to date are recorded and filed. Computerized data is backed up to prevent its loss.

	2. The Vurhonga 2 project should continue monitoring the volunteer activities in the Vurhonga 1 project to document and learn from the sustainability of the CG approach. In particular, the animators should continue collecting mortality and other indicator data maybe once a year.	Supervisors and Animators	Yearly

Response: A supervisory visit was made in April'02 to Mabalane and Guija, the 2 districts of Vurhonga I. The aim of the visit was to evaluate knowledge levels and key practices at the household level, to see how they compared with end of project performance 30 months prior. Staff used the same questionnaire that is used for Vurhonga II quarterly surveys. To avoid bias each Animator who had worked in the first project area was accompanied by either a new Animator from Vurhonga II or a Supervisor or Driver. Through the drawing of lots Care Groups were selected and all households belonging to selected Care Groups were surveyed. All indicators that overlapped with Vurhonga II (because the Vurhonga II instrument was used) were still above the end of project targets for Vurhonga I. These results were maintained in spite of the fact that a number of key MOH personnel was transferred or retired since the conclusion of Vurhonga I in Mabalane and Guija. Please see Section H for more detail on these impressive results.

	3. WR should plan on including the Vurhonga 1 area and achievements in the final evaluation of the Vurhonga 2 in 2003.	Evaluation team	Aug.'03

Response: For action at time of Final Evaluation.

I	**Program Management (Planning)**		
	1. The Vurhonga project staff should prepare and translate a summary of the key technical elements of the DIP including of the child survival interventions, the capacity building and partnership approaches, the project objectives and indicators, and the monitoring and evaluation plan. This document should be shared with the project and MOH staff, and possibly with other partners in Chokwe and at the Provincial and National level.	Project Director Translator	Febr.'02

Response: The following important documents have been translated for use by Vurhonga staff, MOH and other interested partners:

- All the MTE recommendations with persons responsible and target dates.
- All the project objectives (with targets and actual values)
- The *socorrista* monitoring plan
- The Care Group monitoring plan
- The project evaluation plan and forms.
- The Village Health Committee guidelines and possible objectives.
- Training of Trainers Manual to assist Care Group leaders in teaching all interventions to their Care Groups (in local language Shangaan)

J	**Staff Development and Management**		
	1. The Vurhonga project should prepare a training of trainers (animators) manual that include all the technical educational materials used by the volunteers and all the training, managerial and leadership skills that the Vurhonga project teaches them.	Admin. assistant	Dec.'02

Response: Two Training manuals have been created and translated into the local language (Shangaan) for use by the Care Group leaders, *Chefes de Saude* and MOH. The first manual is on Malaria, Diarrhea, Pneumonia, Malnutrition and General Danger Signs in children under 5. The 2nd manual is on reproductive health (Maternal care, Family planning, HIV/AIDS and STIs.) They are both ready and will be printed in November 2002.

E. Phase-out plan

Vurhonga CSP activities were explicitly designed so that once established, village structures including Care Groups of volunteers and VHCs could continue to address the health needs of their communities independent of paid Vurhonga Animators. Likewise, the MOH will continue to supervise *socorristas* trained during the project and manage data from the Community HIS, in addition to relating to communities via VHCs and the Care Group network.

Specific elements of the Vurhonga II phase out strategy in Chokwe are as follows:

1. *Volunteers should together pass oral tests at the end of each intervention. All the volunteers in a group will undergo oral exams at the end of each intervention. The average of the group should be at least 60% for the group to pass.*

   Comment: Due to the time lost as a result of the floods we have decided to do one exam at the end of the project when all the interventions have been reviewed for the 2nd time instead of an exam at the end of each intervention. This will save at least 14 weeks in which revision can be done.

2. *Care group leaders will be trained to take over the function of the Animators pertaining to the training and supervision of the volunteers.*

   Comment: All Care Group leaders have undergone special training during the month of July'02 to equip and capacitate them to take over the function of the Animator for their individual Care Group. Training topics included review of the health curriculum, leadership and the importance of vision. *Chefes de Saude* and village leaders were also included in the same training.

   The CG leaders started to train their volunteers in August'02. The Animator attends each training session to support the CG leader and add anything that may have been left out. Afterwards, she meets one on one with the CG leader to discuss the session and provide feedback on training technique.

3. *Preparation of a user-friendly manual that includes all the health interventions with pictures for the CG leaders, Chefes de Saude and Socorristas to use.*

   The manual has already been written and consists of 2 parts: Part one includes the interventions related to IMCI (Malaria, Diarrhea, Pneumonia and Nutrition) and part 2 includes all the interventions related to Reproductive health (Family planning, STI/HIV/AIDS and Maternal care).

4. *Formation of Village Health Committees in each village in Chokwe district.*

   Vurhonga II began forming Village Health Committees from very early in the project, just after Care Group volunteers and leaders were selected. The early start allowed

sufficient time for members to mature in their understanding of the needs for such a committee, and to iron out difficulties as they arose. This investment in training and mentoring is already showing fruit. As mentioned, over 85% of the 48 VHCs now meet during any two-month period and there is ample evidence of their ability to demonstrate initiative, set goals and solve problems pertaining to health at the community level.

5. *Capacitate and equip a MOH official to be responsible for the monitoring and supervision of all activities related to the Socorristas and indirectly to the volunteers.*

   The nurse (Inacio Xithlangu) in charge of health statistics for the District MOH has accepted responsibility for the supervision of *Socorristas* and indirectly for the volunteers. The connection between the nurse statistician and the *Socorristas* is a natural fit since *Socorristas* are responsible for combining Community HIS data from the care groups with their reports on patients treated at the village health post. Though the *Socorristas* receive technical supervision from the MOH, they report to their respective village health council for matters related to fee schedules, work hours, and patient interaction.

   The project has actively invested in the skills of the MOH *Socorrista* Supervisor with regard to data management and monitoring and supervision, as already mentioned.

6. Factors influencing Program Management

Financial management: The Vurhonga II project in Chokwe relies on the timely financial feedback it gets from the WR financial department in Maputo in order to effectively plan activities. Timely feedback was a problem at the beginning of the project but has significantly improved over the last 12 months.

Human resources: All the Vurhonga I staff continued in Vurhonga II except for one Animator that died earlier this year. She was replaced by a new Animator.

Communication: Due to the floods in 2000 the telephone network in Chokwe has been chronically unreliable. This did not negatively impact on the project so much as it challenged the staff to exercise patience and plan ahead for communication needs as service at any given time could not be relied upon. As of the end of September, telephone access has become much more reliable.

Local partner relationships: Relationships with the MOH has been very positive during the life of the project. This includes relations at village level between the Animators, volunteers and nurses and *Socorristas* as well as at district level between the MOH leadership, the Vurhonga leadership and the project as a whole. Possible factors contributing to this include:

a. A positive and respectful attitude of project Animators.
b. Dedication of the Vurhonga staff to achieving project goals and objectives.
c. Praise from the Provincial MOH leadership for improved district statistics.
d. Trust resulting from a strong work ethic and faithfulness to the communities.
e. The project director's joint appointment at the district hospital one day per week.

PVO coordination/collaboration: Save the Children began work in Gaza Province on a USAID Mozambique Mission-funded IMCI grant during the second year of Vurhonga II. As many goals and objectives were similar, Vurhonga worked carefully with Save the Children so as to complement rather than duplicate efforts. Save the Children had planned to train one volunteer per village expected to visit all families and refer sick children to the health post. Instead, Vurhonga proposed that the CSP Animators receive the training so that they could share it with the Care Groups, training many more volunteers with a more manageable caseload of homes to visit. This proposition was accepted and Save the Children trained the Vurhonga animators in October 2002.

Organizational capacity assessment: World Relief underwent an Institutional Strengths Assessment (ISA) in February 2002. The ISA was conducted by external evaluators from CSTS and CONCERN Worldwide, and included participation by all relevant World Relief headquarters staff, and 3 out of the 4 Child Survival Program field staffs.

The ISA explored six interactive areas of overall organizational capability. The core element of the instrument was comprised of a questionnaire on which respondents rated the headquarters health division on multiple indicators within each area. The team complemented these findings with written recommendations from the field unit and recommendations and discussion of the headquarters staff over several hours of group meetings facilitated by the evaluators. As the ISA constitutes a first step in organizational strengthening, PVOs are allowed to keep their results confidential, however World Relief would like to share a summary of what they learned from this exercise.

The outside facilitators observed:

- Since World Relief has considerable experience of implementing Child Survival programs, they can draw on their experiences with other programs when confronting issues arising in new ones.
- Present staffing of the Health Technical Unit represents a diverse array of expertise that offers a range of resources in technical areas to field projects; they provide both direct, on-site support and long distance technical support.
- There has been little recent turnover of key project staff in Health Unit or at Field Sites. Majority of Health Unit members moved with the organization to Baltimore, ensuring continuity in International Health Programs.
- There is an established system of progress reports going from the field to health unit; the health unit is able to source the input of consultants when appropriate.
- The health technical unit and larger organization clearly recognize weaknesses and are taking clear steps toward addressing those issues.
- There is a high degree of agreement that the support received from the health unit has increased the capacity of field staff to implement quality programs.

- Much discussion focused upon the issue raised most frequently by the field—improving the communication between projects. Several strategies were devised to address this issue and are in the process of being implemented.

Overall, the ISA was deemed helpful to both HQ and field staff in both identifying areas in need of improvement and also in pointing out many strengths. When given the opportunity to reflect on World Relief's health portfolio, the World Relief staff and the external evaluators were impressed by their overall performance. A relatively small Headquarters staff was deemed successful in managing a portfolio of 17 discreet projects in 12 countries.

H. Scaling-up

Over seven years, the work of World Relief, we have modeled a partnership with the Ministry of Health that has transformed the health of entire communities in a sustainable relationship to the essential services provided by the MOH. Because we have continued to track health indicators and the activity of volunteers in Guija and Mabalane, the two districts covered in the first Vurhonga project, we are able to demonstrate a remarkable level of sustained community action, individual behavior change, and improved government services.

Vurhonga I ended on September 30, 1999. In March 2002, we measured behavior change in about one-eighth of the total population randomly selected by care group clusters. The graphs following the text of this section demonstrate that the changes introduced in the original program had been sustained. A full thirty months after the end of the project, the participants in Vurhonga I continued to exceed the final program goals (bottom line) on eight key indicators.

A closer look at the eight indicators shows not only the steep increase from the baseline seven years ago but also demonstrates change that goes well beyond individual behaviors. Without the continued work of the volunteers, there probably would have been significant attrition in all of these indictors over two and a half years. Only the indicators for receiving additional food during pregnancy and diarrhea concern only individual behaviors. The two indicators for nutrition—the number of children being weighed and mothers receiving nutritional counseling--depend upon the continuation of community-based services by volunteers and village health committees. The remaining four indicators concerning ORS, malaria treatment, use of modern family planning methods, and completed immunizations require not only individual behavior change but also sustained services by the MOH at a local level.

A survey of all of the volunteers in Vurhonga I two and a half years after the end of the project demonstrates an extraordinary community commitment. Of the 1457 volunteers active at the end of the project, 1361 (93%) were active thirty months later. Of the original number, 92 had left their post or moved out of the area and 44 had died. Out of these 132 vacant roles, the communities had selected 40 replacements. Other volunteers trained their new colleagues and entrusted them with the educational materials of their predecessors. Community members confirmed that the volunteers had continued their work. Women in half of the households reported that their volunteer had visited their household within the last two weeks.

Rich anecdotal data also supports these findings. In one village, when the village health committee discovered that an increasing number of children were malnourished because of the

food crisis in the region, the community re-instituted the HEARTH program to successfully address the situation.

Three years into Vurhonga II, the pattern is replicating itself. At the end of three years we have exceeded the end of project goals on 22 of 24 measurable indicators. The volunteer retention rate for over 2200 volunteers is higher than the Vurhonga I project at the equivalent time. The indicators addressing the relationships between the community members, village health committees and the MOH are outstandingly high.

World Relief has used the care group model in child survival projects in Malawi and Cambodia with similar results and shared information concerning this strategy within the CORE group, at annual meetings of the American Public Health Association and in presentations at schools of public health.

How can this be scaled-up?

The senior officials in the Ministry of Health in Gaza Province and each of the senior officers in five districts of Gaza have urged World Relief to scale up this program so that, along with the work of Vurhonga I and II, it encompasses eight of the eleven districts in the province.

At first glance, this does not seem to be an easily scalable program. It encompasses a fully integrated approach to community IMCI rather than focuses on one or two successful vertical interventions. It intentionally targets not only individual health behavior change but also the health-related beliefs, values and behaviors of entire communities and fundamental redefinition of interactions between the communities and the MOH.

“Going to scale” depends upon two defining factors in the model. First, at a strategic level, the approach demonstrates a partnership model between ministries of health (or other partners that provide essential preventative services) and a PVO or NGO. The success of the partnership does not depend upon the long-term presence of the PVO, however, but upon community-based sustainability and redefining the relationship between the community and MOH services that are strengthened by the PVO to build lasting capacity. From our own experience in child survival projects in other places in Africa and in Southeast Asia, we recognize that this model is successful on a smaller scale. Scaling-up the model in Gaza Province would provide the first test for the model on a regional basis and will help address the conundrum of how to scale up integrated community health programs.

Second, at community level, the approach demonstrates how specific health interventions may be built into a sustainable community movement for better health, not isolated to the behaviors of individual women and children, but reflected in long-term community action. The care group model, the sustainability interventions with village health committees, the integration of community and MOH systems and the use of traditional media and sensitivity to community relationships all contribute to this transformation. Again, we are anxious to build upon our experience in three districts to bring this to scale in eight of eleven districts within the same province.

Sustainability of Final Project Goals Thirty Months after the end of Vurhonga One

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